

Physician-Focused Payment Model Technical Advisory Committee

Panel Discussion 1: *Improving Management of Care Transitions from Facilities to the Community*

Panelists:

Subject Matter Experts

- [Scott A. Berkowitz, MD, MBA](#) – Chief Population Health Officer, and Vice President, Johns Hopkins Medicine; and Associate Professor of Medicine, Division of Cardiology, Johns Hopkins University School of Medicine
- [Robert A. Zorowitz, MD, MBA](#) – Regional Vice President, Health Services for the Northeast, Humana

Previous Submitter

- [Karen S. Johnson, PhD](#) – Vice President, Practice Advancement, American Academy of Family Physicians (AAFP) (*Previous Submitter – APC-APM proposal*)

**Panel Discussion 1: *Improving Management of Care Transitions
from Facilities to the Community***

Karen S. Johnson, PhD

Vice President, Practice Advancement
American Academy of Family Physicians (AAFP)
(Previous Submitter – APC-APM proposal)

Karen Johnson

Introductory Comments

PTAC Public Meeting

Panel Discussion 1: Improving Management of Care
Transitions from Facilities to the Community

June 12, 2023



Karen S. Johnson, PhD

American Academy of Family Physicians (AAFP)

- The AAFP serves 129,600 family physicians with education and advocacy focused on strengthening the primary care foundation of the US health care system.
- Vice-President, Practice Advancement since 2021 and strong primary care advocate throughout my career including the following roles:
 - Benefit consultant to large self-funded employers and union trusts
 - Health plan payment strategies including primary care and value-based payment model design
 - Multi-stakeholder collaboration
 - Data-driven improvement initiatives

Care Transitions: A Primary Care Perspective

Successful transitions start with timely and accurate information as reflected in the [AAFP Guiding Principles for Value-Based Payment](#).

- Barriers to this happening persist:¹
 - Difficulty locating address of the physician/provider
 - EHR has difficulty receiving information
 - Correctly matching patients across systems and to the correct physician/provider
 - Resources to support social needs may be lacking
- Solutions must be embedded in a complex maze of policy and practice considerations to have an impact.
 - The typical primary care physician caring for Medicare patients must coordinate care with 229 other physicians working in 117 practices.²
 - Practices frequently contract with 10 or more payers.³



Appendix

References

¹ Holmgren AJ, Everson J, Adler-Milstein J. Association of Hospital Interoperable Data Sharing With Alternative Payment Model Participation. *JAMA Health Forum*. 2022;3(2):e215199.

² Pham HH, O'Malley AS, Bach PB, Saiontz-Martinez C, Schrag D. Primary care physicians' links to other physicians through Medicare patients: the scope of care coordination. *Ann Intern Med*. 2009 Feb 17;150(4):236-42

³ American Academy of Family Physicians Practice Profile Survey, 2022

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

**Panel Discussion 1: *Improving Management of Care Transitions
from Facilities to the Community***

Scott A. Berkowitz, MD, MBA

Chief Population Health Officer, and Vice President, Johns Hopkins Medicine;
and Associate Professor of Medicine, Division of Cardiology,
Johns Hopkins University School of Medicine



Scott Berkowitz, MD, MBA

Introductory Comments

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Care Transitions from Facilities to the Community

Scott Berkowitz, MD, MBA

Chief Population Health Officer & Vice President, Population Health, JHM
Associate Professor of Medicine, Division of Cardiology, JHU School of Medicine



Dr. Berkowitz is a practicing general cardiologist who provides strategic direction, leadership, and management of population health activities across Johns Hopkins Medicine (JHM).

In late 2020, he launched the JHM Office of Population Health (OPH) to standardize, coordinate and deploy population health activities and services in a strategic and data-driven way with a focus on enhancing value and reducing disparities.

Scott Berkowitz, MD, MBA

Chief Population Health Officer & Vice President, Population Health, JHM
Associate Professor of Medicine, Division of Cardiology, JHU School of Medicine



JHM, headquartered in Baltimore, Maryland, is a \$10 billion integrated global health enterprise and one of the leading health care systems in the US. It includes >40,000 full time faculty and staff, and operates six academic and community hospitals, four health care and surgery centers, more than six ambulatory surgery centers and has more than 2.8 million outpatient encounters per year.

Care Transitions

Increased Patient Complexity and Reduced System Capacity

- Patients require transitions of care that address post-discharge clinical needs while also addressing social determinant of health issues. Growing patient complexity has complicated this transition.
- **“Bundled” hospital discharge strategies include:**
 - a) risk screens/tools;
 - b) inter-disciplinary care rounds;
 - c) patient/family education;
 - d) medication management;
 - e) primary care handoff;
 - f) ED management; and
 - g) transitions of care support (transition guides, patient access line, community social work, appropriate referrals, etc.).

Care Transitions

Increased Patient Complexity and Reduced System Capacity

- The OPH cross-functional care team seeks to identify newly high-risk patients and provide “in reach” to hospital teams to facilitate a smooth transition and engagement in ambulatory care support.
- JHM has had a post-acute care collaborative to facilitate discharges to SNFs, and in the “post-COVID” era, is seeking to re-envision a care continuum model inclusive of subacute settings and home and community-based services to improve capacity and smooth/timely transitions.

Appendix

References



Fast Facts: Johns Hopkins Medicine. [JHM-Fast-Facts.pdf \(hopkinsmedicine.org\)](https://hopkinsmedicine.org)

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Berkowitz SA, Parashuram S, Rowan K, et al. Association of a Care Coordination Model With Health Care Costs and Utilization: The Johns Hopkins Community Health Partnership (J-CHiP). *JAMA Network Open*. 2018 Nov;1(7):e184273.

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Berkowitz SA, Norman T, Sowers K. Planning for the Future of Population Health: The Johns Hopkins Medicine Experience. *American Journal of Managed Care*. In press.

**Panel Discussion 1: *Improving Management of Care Transitions
from Facilities to the Community***

Robert A. Zorowitz, MD, MBA

Regional Vice President, Health Services for the Northeast
Humana



Humana.

Robert A. Zorowitz, MD, MBA
Regional Vice President, Health Services
Humana, Inc. (Northeast Region)

Robert A. Zorowitz, MD, MBA, FACP, AGSF, CMD

- Regional Vice President, Health Services for Northeast Region of Humana, Inc., since 2020
- Provides Medicare Advantage plans to: NJ, NY, New England, PA, MD, DE and DC
- Oversees Utilization Management and Clinical Programs and Activities
- Background:
 - Albany Medical College, Albany, NY (MD)
 - Long Island Jewish Medical Center, New Hyde Park, NY (Internal Medicine)
 - Mount Sinai Medical Center, New York, NY (Geriatric Medicine)
 - ABIM Certified: Internal Medicine, Geriatric Medicine, Hospice/Palliative Medicine
- Advisor to the AMA CPT Editorial Panel for the American Geriatrics Society, since 2003
 - Helped draft Transitional Care Management Services CPT Codes 99495-99496

Transitional Care Management (TCM) Services

- A Care Transitions program utilizing a “transition coach” and other required components reduced risk of rehospitalization by about 1/3 at 30 days and reduced mean hospital costs by about \$500 at 180 days (Coleman EA et. al. Arch Int Med. 2006;166:1822-1828)
- A nurse-led hospital discharge and home follow-up program for chronically ill older adults reduced rehospitalizations by 30-50%, saving approximately \$4500 per patient within 5-12 months after discharge (Naylor MD et. al. JAMA. 1999;281:613-620 and Naylor MD et. al. J Cardiovascular Nursing. 1999;14:44-54)
- Transitional Care Interventions vs. Usual Care reduced hospital readmissions and/or emergency room readmissions from nursing facilities by 1.7 times (Birtwell et. al. JAMA Netw Open. 2022;5:e2210192)
- Reimbursement for Transitional Care Management Services (CPT Codes 99495-99496) approved by CMS in 2013
- TCM Services are infrequently billed; 3.1% of eligible discharges in 2013 and 7.0% in 2015 (Bindman AB, Cox DF. JAMA Intern Med. 2018;178:1165-1171); in 2019, Of all beneficiaries with acute care discharges eligible for TCM, only 17.9 percent received TCM services (Colligan E. et. al. Analysis of 2019 Medicare Fee-for-Service (FFS) Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services March 1, 2022. NORC/University of Chicago)

Appendix

Transitional Care Management (TCM) Services

Commencing on day of discharge through 29 days from discharge, TCM includes all non-face-to-face services provided by clinical staff under the direction of the physician or other qualified healthcare professional

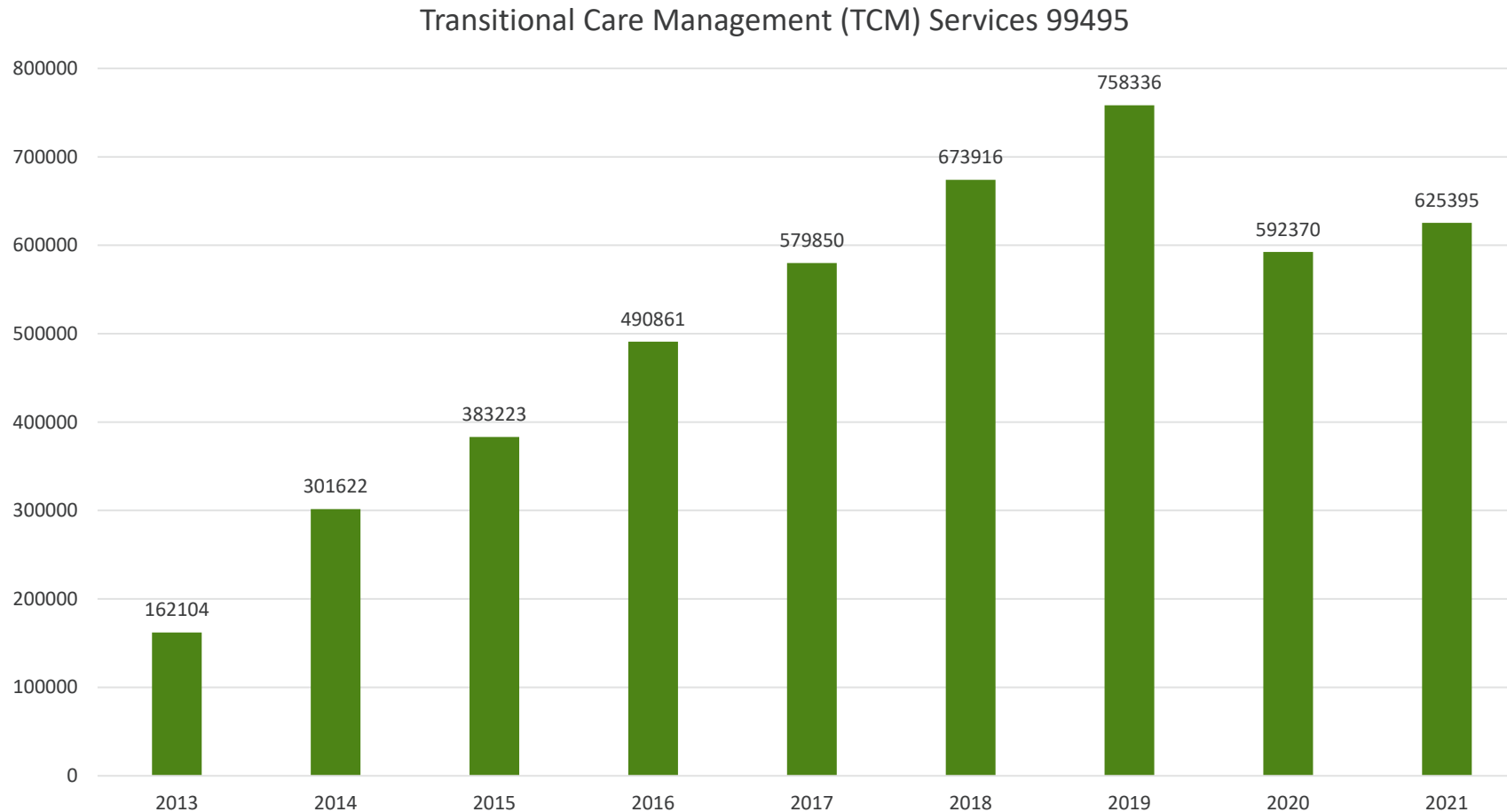
99495 Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 Transitional Care Management Services with the following required elements:

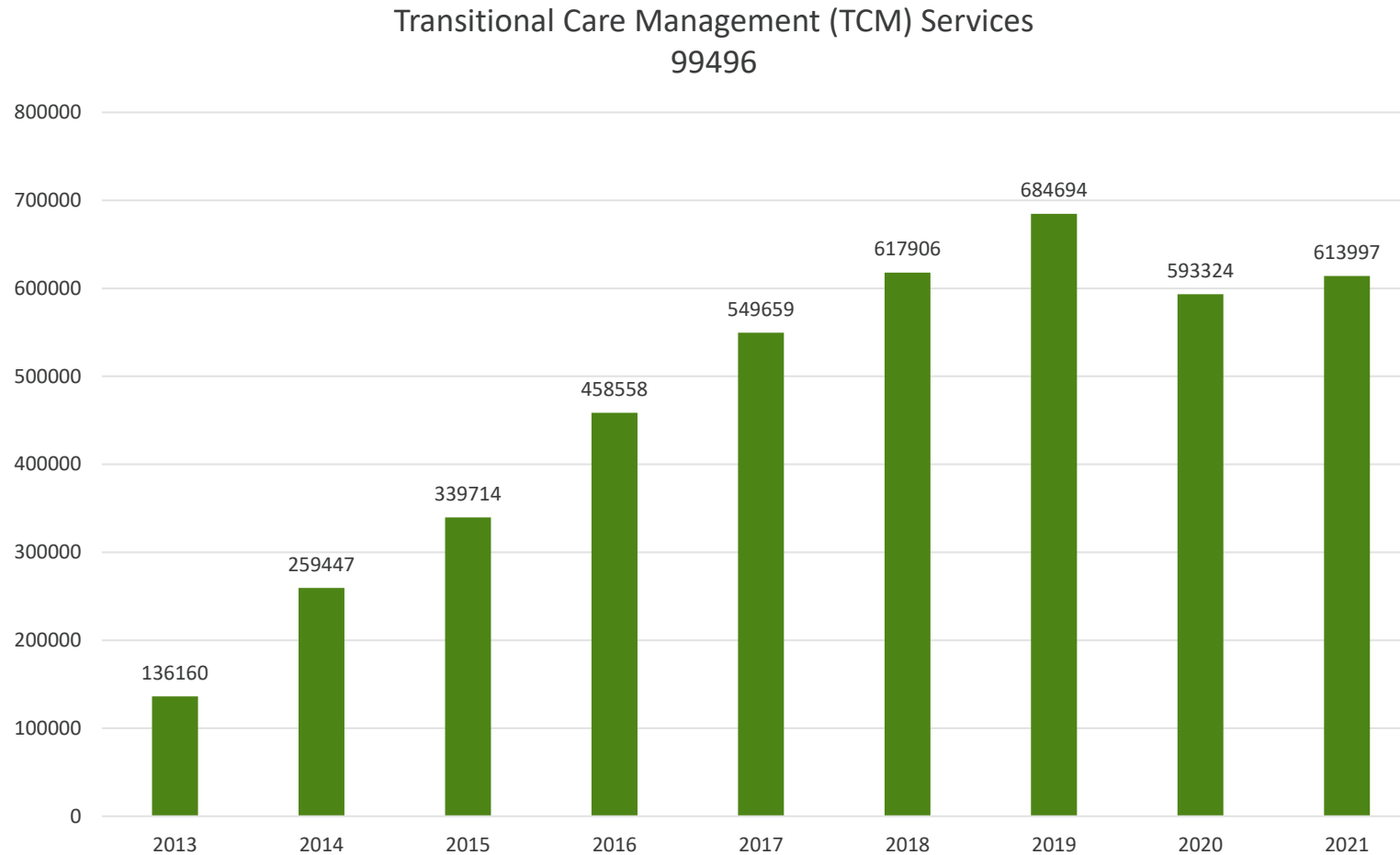
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

Transitional Care Management (TCM) Services 99495 Medicare Fee-for-Service Claims 2013-2021



99495 Transitional Care Management Services with *moderate* level medical decision-making

Transitional Care Management (TCM) Services 99496 Medicare Fee-for-Service Claims 2013-2021



99496 Transitional Care Management Services with *high* level medical decision-making

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- Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med*. 2006 Sep 25;166(17):1822-8. doi: 10.1001/archinte.166.17.1822. PMID: 17000937.
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Panel Discussion 2: *Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions*

Panelists:

Subject Matter Experts

- [Charles Crecelius, MD, PhD](#) – Medical Director for Post-Acute Care, BJC Medical Group
- [David C. Herman, MD](#) – Chief Executive Officer, Essentia Health
- [Jenny Reed, MSW](#) – Senior Vice President, Value-based Care, Baylor Scott & White Health
- [Robert M. Wachter, MD](#) – Professor and Chair, Department of Medicine, University of California, San Francisco (UCSF)

**Panel Discussion 2: *Provider Perspectives on Payment Models for
Incentivizing Improved Management of Care Transitions***

Charles Crecelius, MD, PhD

Medical Director for Post-Acute Care

BJC Medical Group

Charles Crecelius MD PhD FACP CMD

- BJC Medical Group Post-Acute Medical Director
 - Oversee Skilled Nursing Facility (SNF) providers, nursing home Preferred Provider Network (PPN), and various transition programs
- Part of BJC HealthCare – consisting of Washington University School of Medicine and faculty, BJC Medical Group, BJC ACO, Barnes-Jewish Hospital and 11 other community hospitals, in the Greater St. Louis area
- 35 years of clinical practice in nursing homes, clinic, and hospital, 5 years of administrative experience
- Extensive work with AMDA, The Society for Post-Acute and Long Term Care Medicine – Past President, Medical Director of the Year, Public Policy Chair and Advisor, AMA Relative Value Update Committee

Communication and Treating in Place Promote Best Transitions

- Communication Barriers in Transitions –
 - Health system adopting SNF specific discharge summary / instructions
 - Working with SNF EMR systems to produce a reliable / improved Continuity of Care document to serve as discharge summary from SNF
- Improving Treatment in Place
 - Urgent & avoidable transitions can be avoided with early identification and aggressive treatment such as IV antibiotic & fluids
 - Previous CMMI demonstration project showed reduction in hospitalizations with mentored nursing staff. Included extra payment to the facility & physician for approved diagnosis needed for extra resources used. 50% and 56% reduction in avoidable readmits and ER visits, respectively. 40% cost reduction in avoidable readmits and 6% reduction in total costs.

**Panel Discussion 2: *Provider Perspectives on Payment Models for
Incentivizing Improved Management of Care Transitions***

David C. Herman, MD

Chief Executive Officer

Essentia Health

Welcome

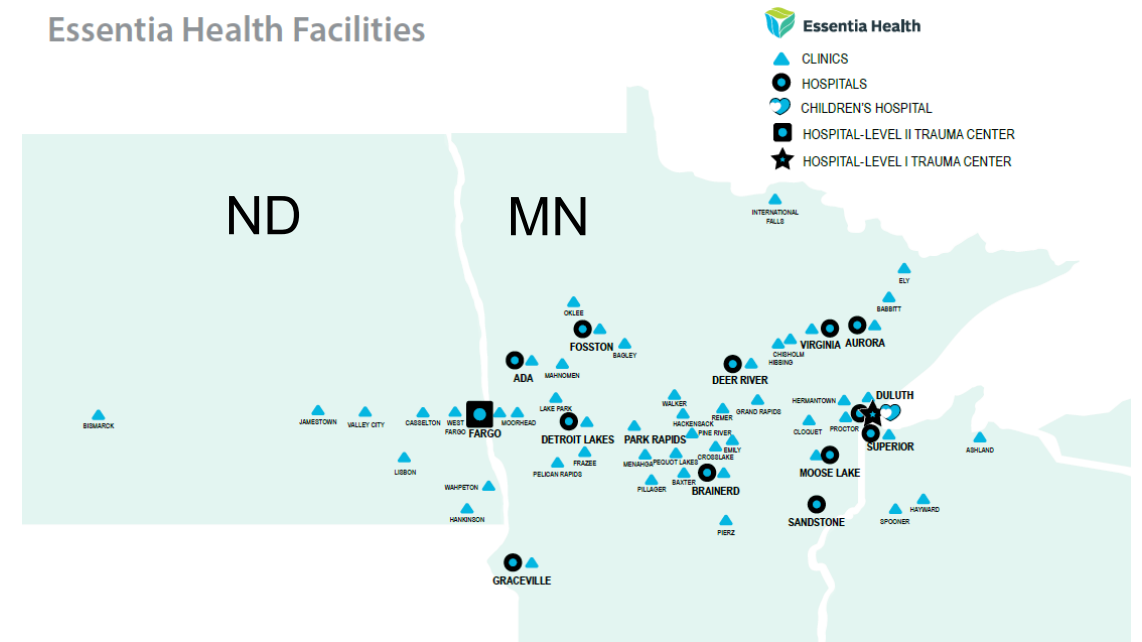


David C. Herman, MD Chief Executive Officer, Essentia Health

Our mission: We are called to make a healthy difference in people's lives.

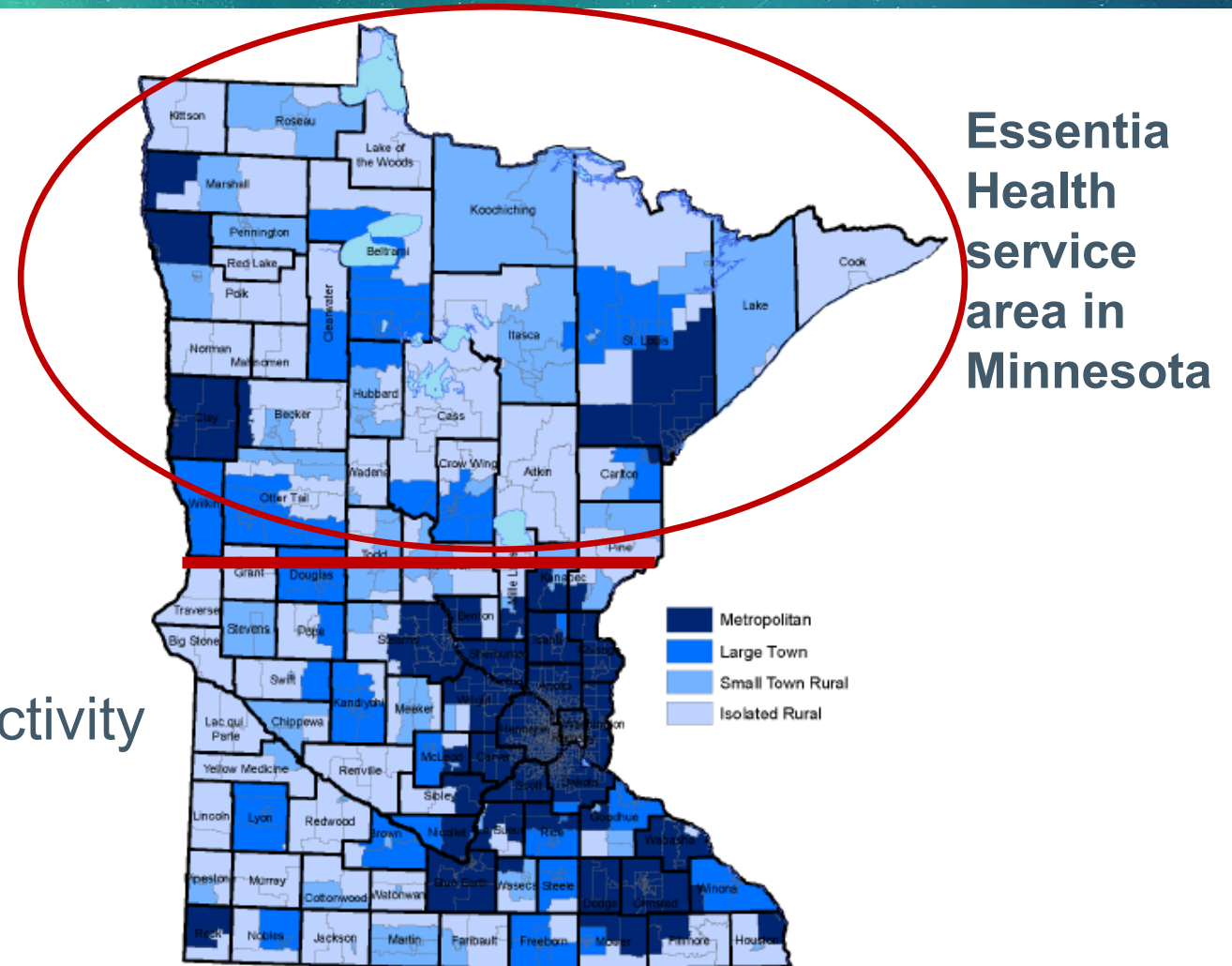
- **15,000** colleagues
- **14** hospitals
- **77** clinics
- **6** long-term care facilities
- **6** assisted living & independent care facilities
- **7** ambulance services
- **1** research institute

Essentia Health Facilities



Rural health care is distinctly different

- Lower household incomes
- Older
- Less education
- More health concerns
- Distance to care is greater
- Relatively resource poor
 - Food deserts
 - Unreliable broadband connectivity
 - Small provider practices
 - Lack of specialty services



We are called to make a healthy difference in people's lives.

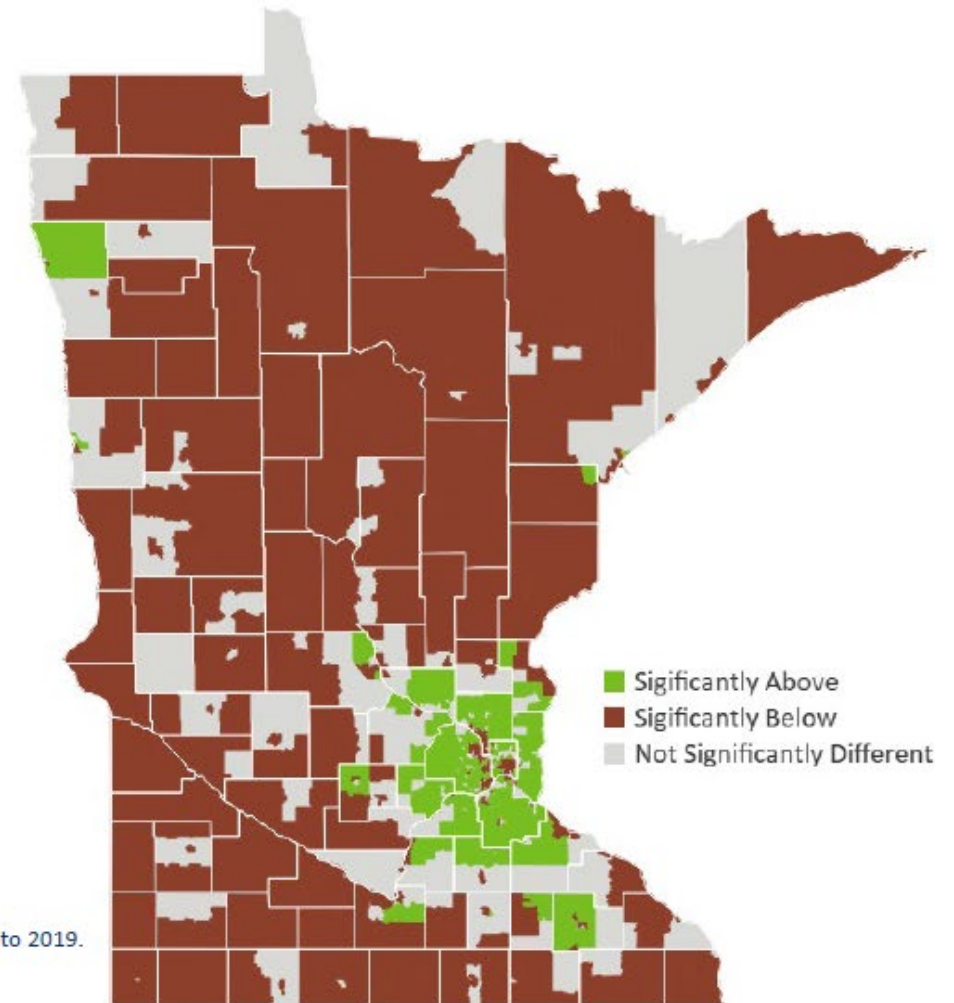
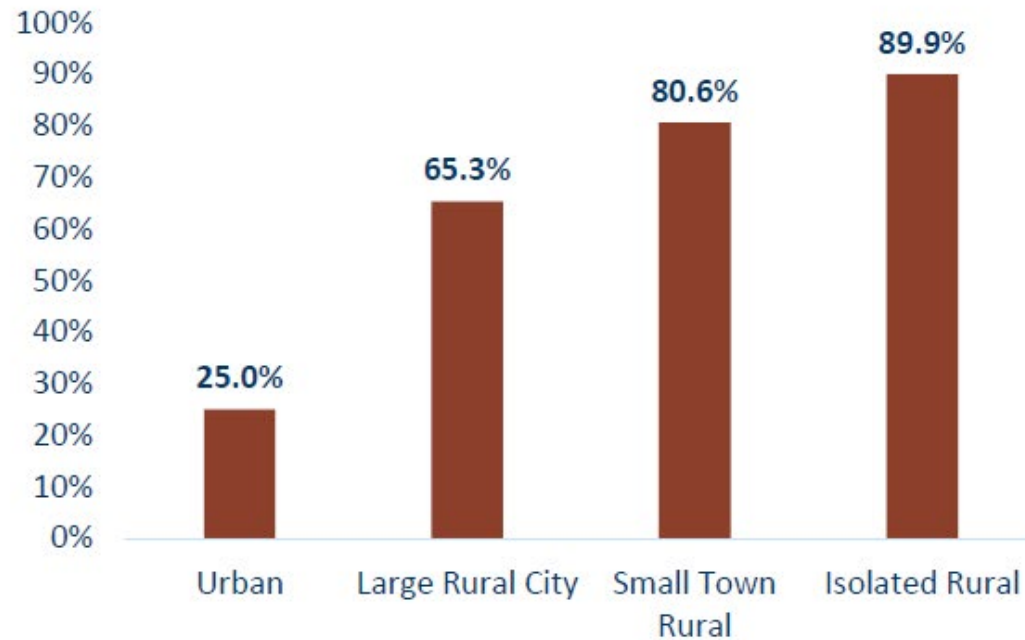
Appendix



Essentia Health

Household income

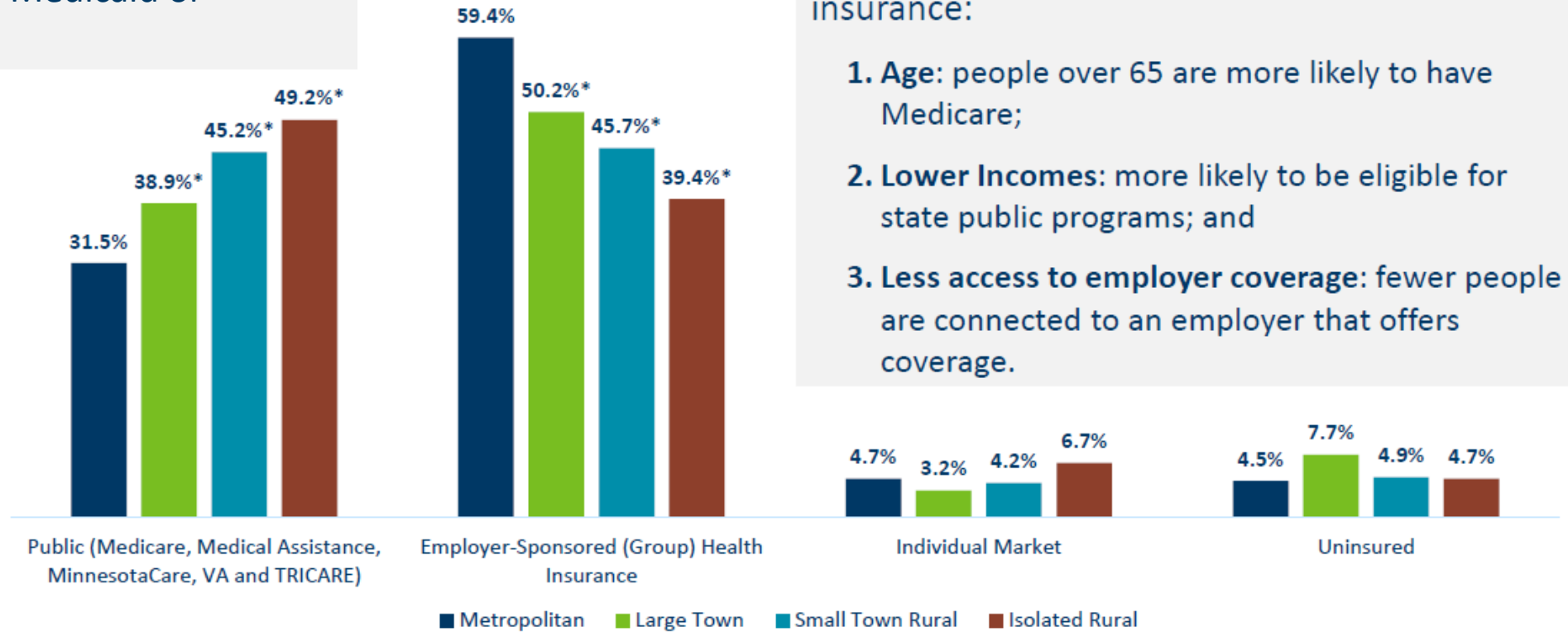
More than three out of four of people living in rural areas have household incomes below the statewide median income



Source: MDH/Health Economics Program analysis of the American Community Survey Five-Year Estimate 2015 to 2019.
RUCA based on census tract
[Summary of Slide](#)

Health insurance coverage

Rural Minnesotans are more likely to have public health insurance coverage, such as Medicare, Medicaid or MinnesotaCare



Reasons for higher rates of public health insurance:

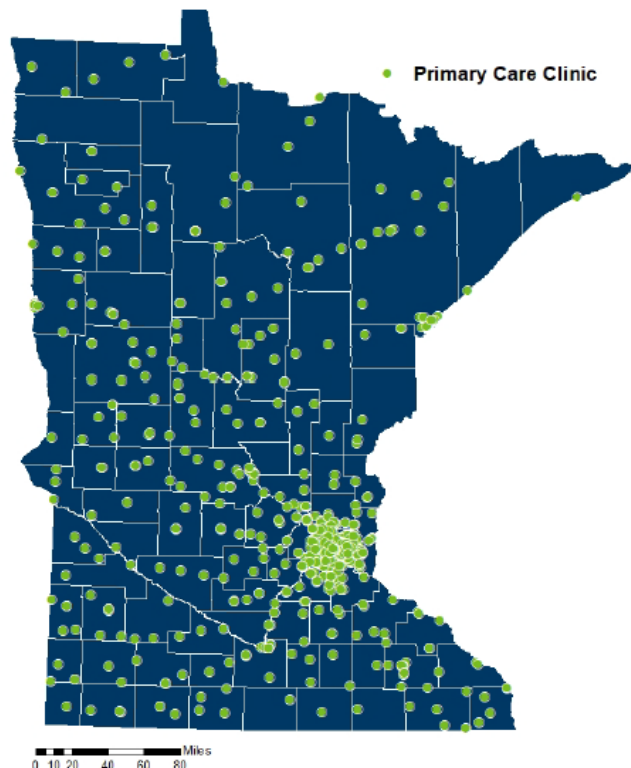
- 1. Age:** people over 65 are more likely to have Medicare;
- 2. Lower Incomes:** more likely to be eligible for state public programs; and
- 3. Less access to employer coverage:** fewer people are connected to an employer that offers coverage.

Source: Minnesota Health Access Survey, 2019; Geographies based on RUCA zip-code approximations.

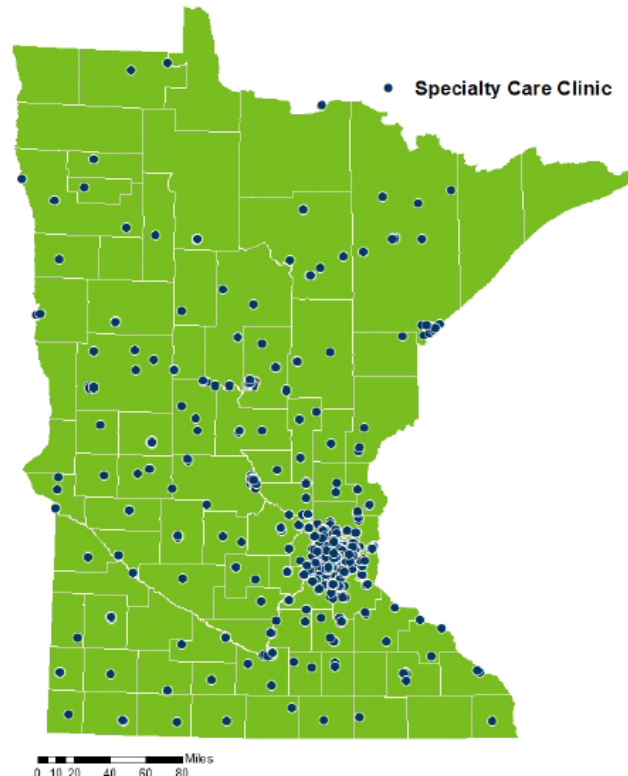
*Indicates significant difference from Metropolitan at the 95% level.

Primary and Specialty Clinics

Primary Care Clinics, 2020



Specialty Care Clinics, 2020



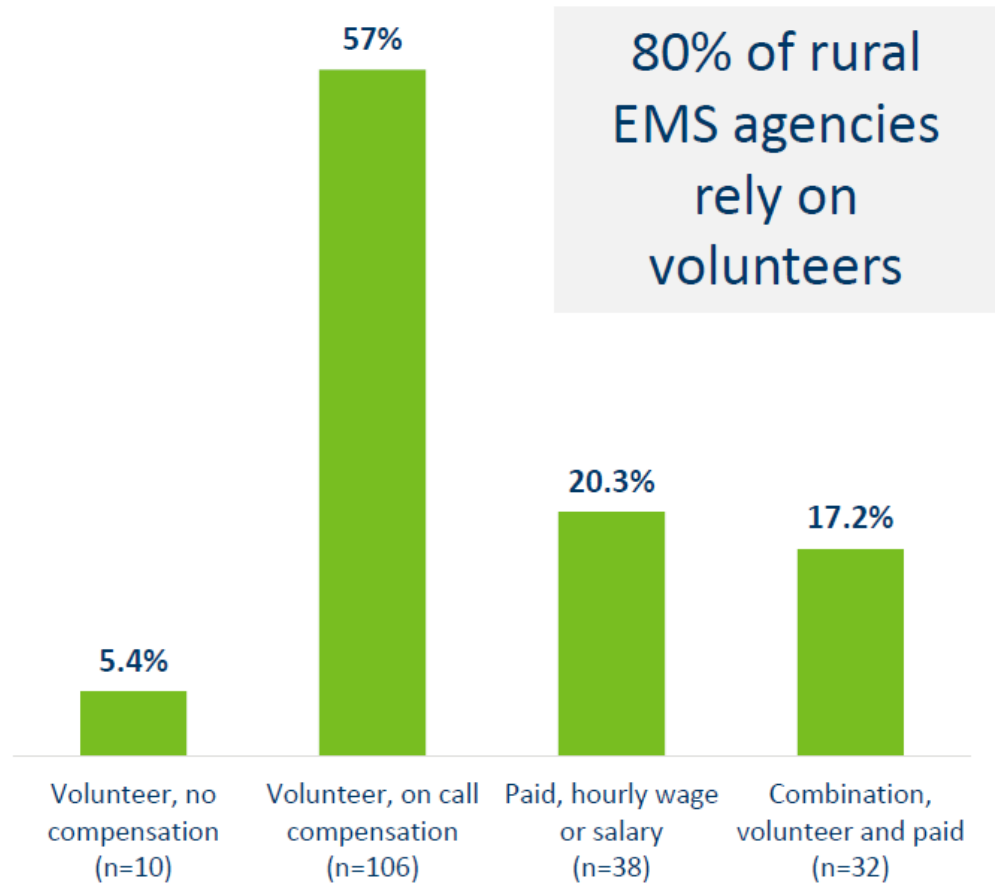
- 37% (242) of all primary care clinics (661) are located in rural areas.¹
- 19% (208) of all specialty care clinics (1,070) are located in rural areas.¹
- Minnesota Community Health Centers had 720,846 medical, dental and mental health visits in 2020.²

Map Notes: Dots represent the number of clinics, and do not account for patient population or number of practicing physicians. Primary Care includes general family medicine, general internal medicine, and general pediatrics; Specialty Care includes one or more non-primary care specialty. 74.3% of the population lives in urban areas, and 25.7% of the population lives in rural areas based on 2019 5-year population estimates and census tract RUCA codes.

¹Source: MDH Health Economics Program analysis of the Minnesota Statewide Quality Reporting and Measurement System 2020 Physician Clinic Registry; also source for maps.

²Source: https://issuu.com/mnachc/docs/mnachc_2020_annual_report.

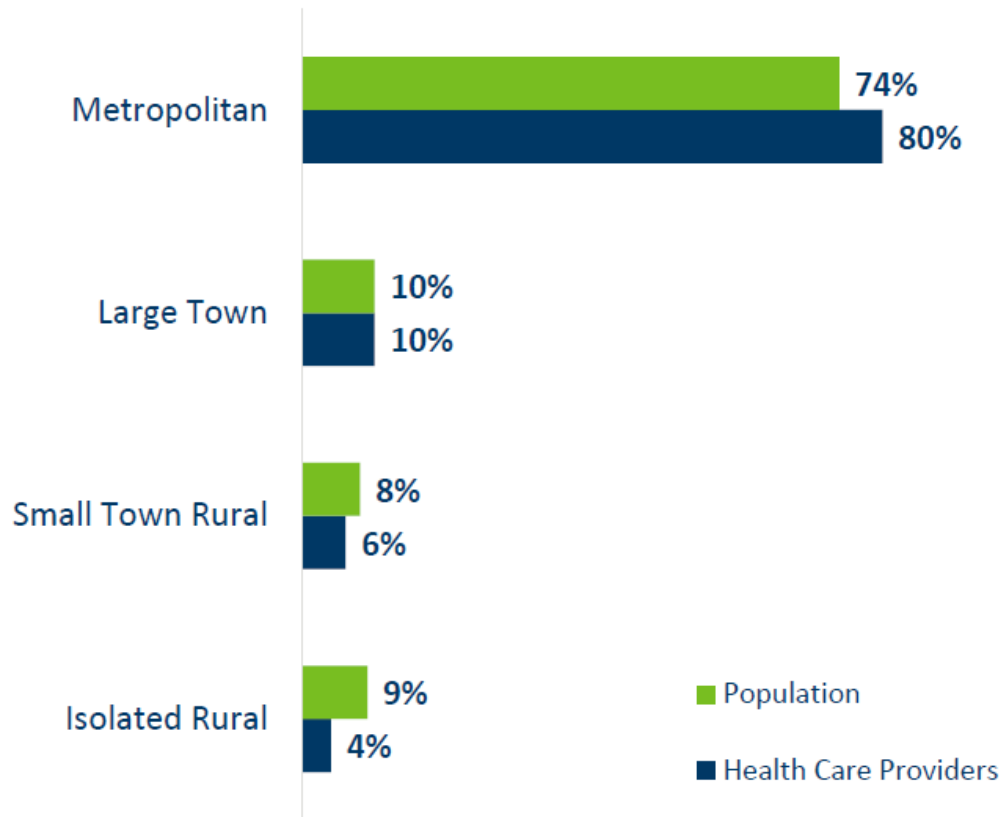
Rural Emergency Medical Services (EMS)



- Rural EMS agencies rely on volunteers, but face decreasing volunteer roster sizes, and many shifts (weekdays, weekends, holidays) are difficult to fill.
- About 60% of agencies have inadequate staff to cover their call schedule without undue burden.
- 59% of agencies do not have all of their shifts covered at least 24 hours in advance.
- 88% of agencies provide Basic Life Support (not paramedic level services) to their communities.

Source: <https://www.health.state.mn.us/facilities/ruralhealth/flex/docs/pdf/2016ems.pdf>
[Summary of Slide](#)

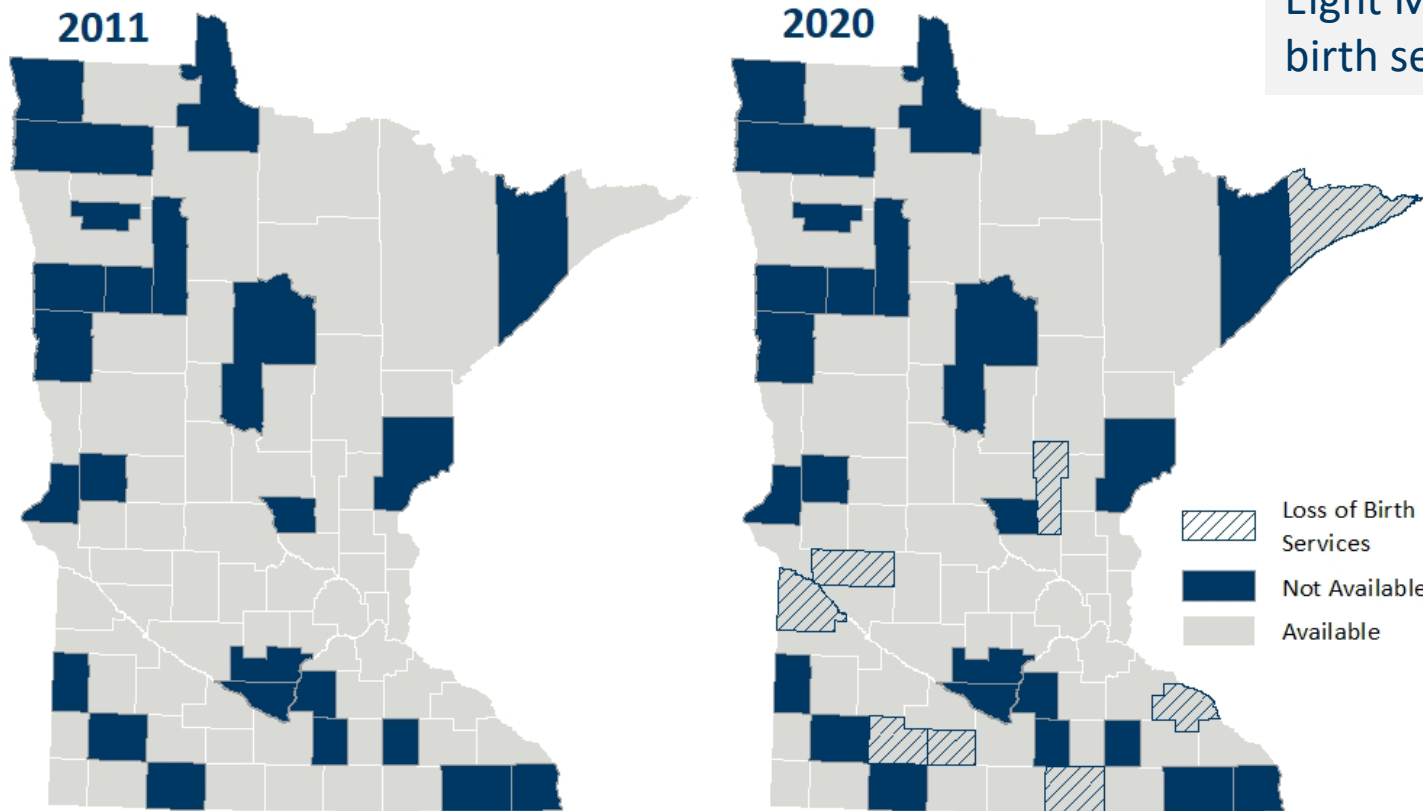
Rural health care providers



Very few licensed health care providers work in rural areas.

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, August 2021. Data includes: physicians, physician assistants, respiratory therapists, oral health professions, pharmacy professions, physical therapy professions, and mental health professions.

Hospital birth services



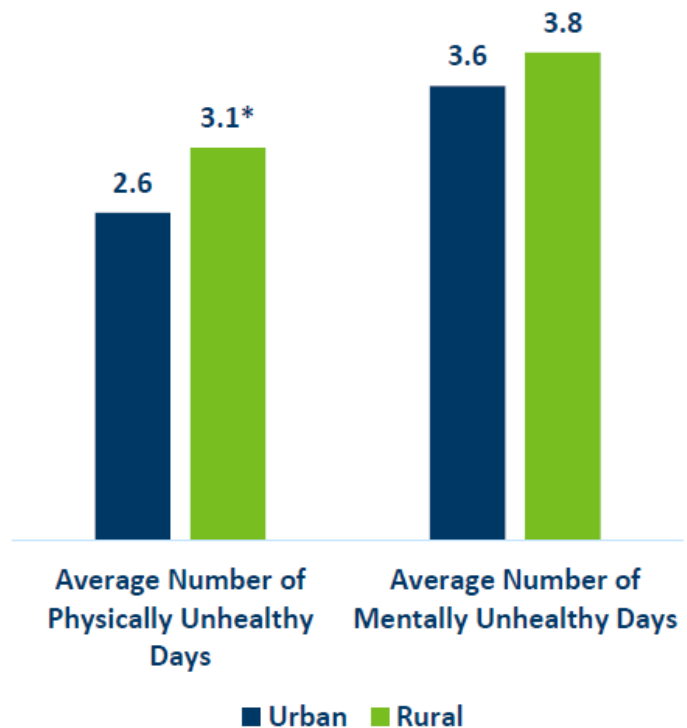
Eight Minnesota counties lost hospital birth services between 2011 and 2020

Increases in pre-term births have been associated with the loss of hospital birth services in rural areas.

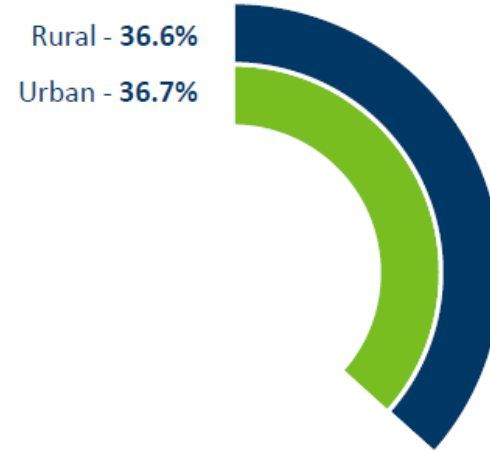
Note: Due to a merger, the hospital in Mower County was no longer an independent licensed entity as of the end of 2014; however, birth services were offered at that site under the license of the remaining corporate entity. The other hospital of the merger, in Freeborn County, no longer has birth services.
Source: Minnesota Department of Health, Health Economics Program Analysis of hospital annual reports, September 2021; 2020 data is considered preliminary; U.S. Census Bureau (County Designations)
Definition: Community hospitals were categorized as not offering birth services if they did not have at least one routine birth and had no licensed bassinets or stated that services were not available.

Rural residents report more unhealthy days

Average Number of Unhealthy Days in Past 30 Days



Percent of Minnesotans with a Chronic Condition



- Minnesotans living in rural areas reported frequent mental distress at about the same rate (12.4%) as those living in urban areas (10.4%).¹
- Age-adjusted suicide rate in greater Minnesota (17.3) was higher than the 7-county metro area (12.2) for 2015-19.²

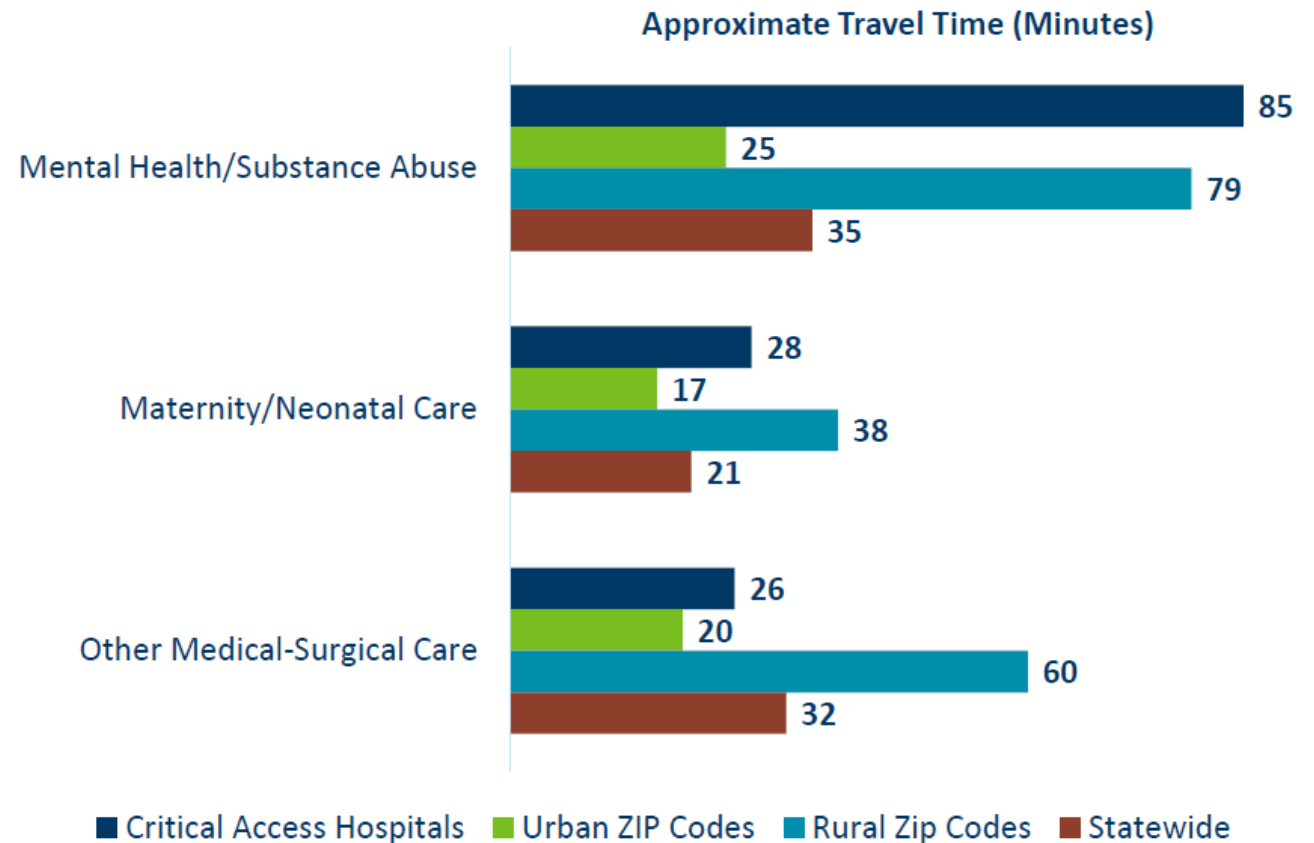
¹ Source: Minnesota Health Access Survey, 2019. Urban and Rural defined based on RUCA zip-code approximations. Difference was not statistically significant.

* Indicates significant difference from Urban at the 95% level.

² Source: 1999-2019: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death on CDC WONDER Online Database, released 2020.

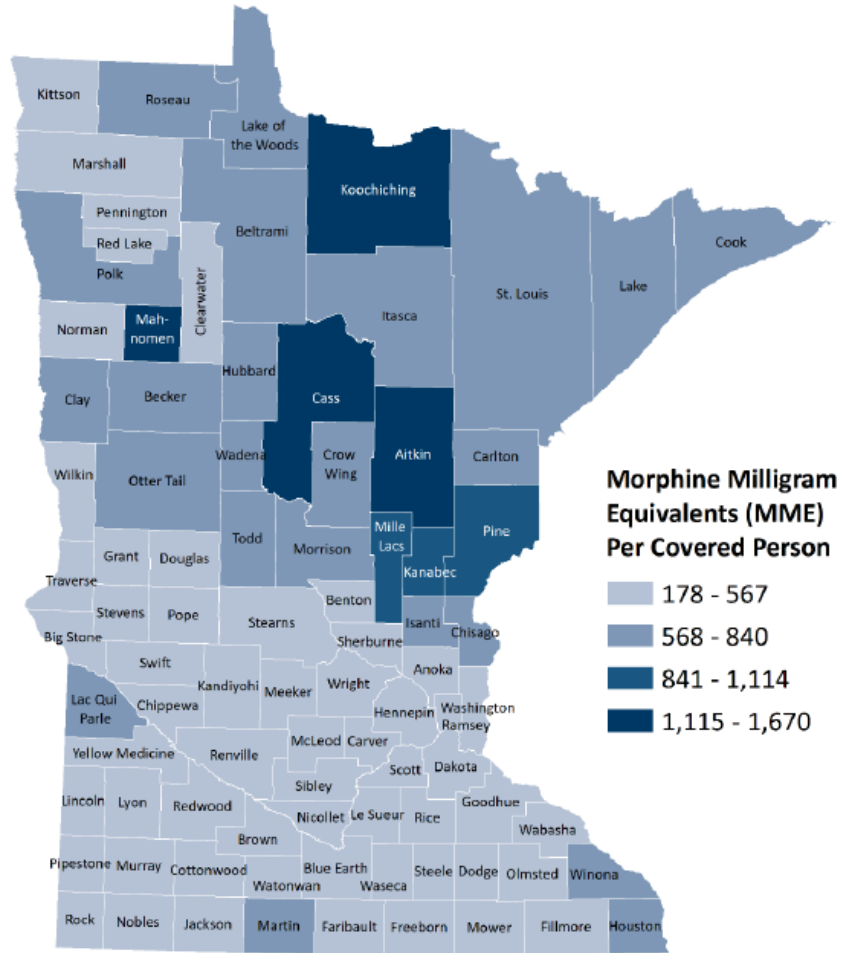
Additional travel to care

- Rural patients seeking inpatient mental health and chemical dependency treatment travel more than three times longer than urban patients.
- Patients receiving medical/surgical care at Critical Access Hospitals experience shorter travel times than those traveling to other types of hospitals.

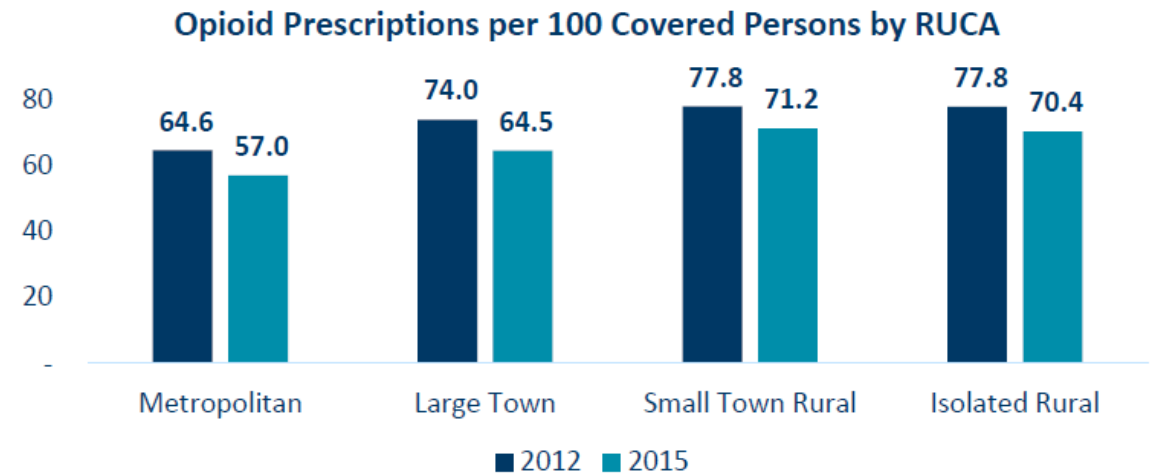


Source: MDH analysis of Minnesota hospital administrative (discharge) inpatient records for medical-surgical care, obstetrics care, and mental health or chemical dependency care for 2016 to 2019. The analysis calculated the distance between the geographic centroid of each ZIP code to respective hospitals and excluded hospital stays that were transferred to another hospital to avoid duplication. Patients with planned services, such as surgeries, may intentionally travel longer distances. Non-metropolitan ZIP codes are classified as 'rural' using RUCA.

Prescription Opioid Use

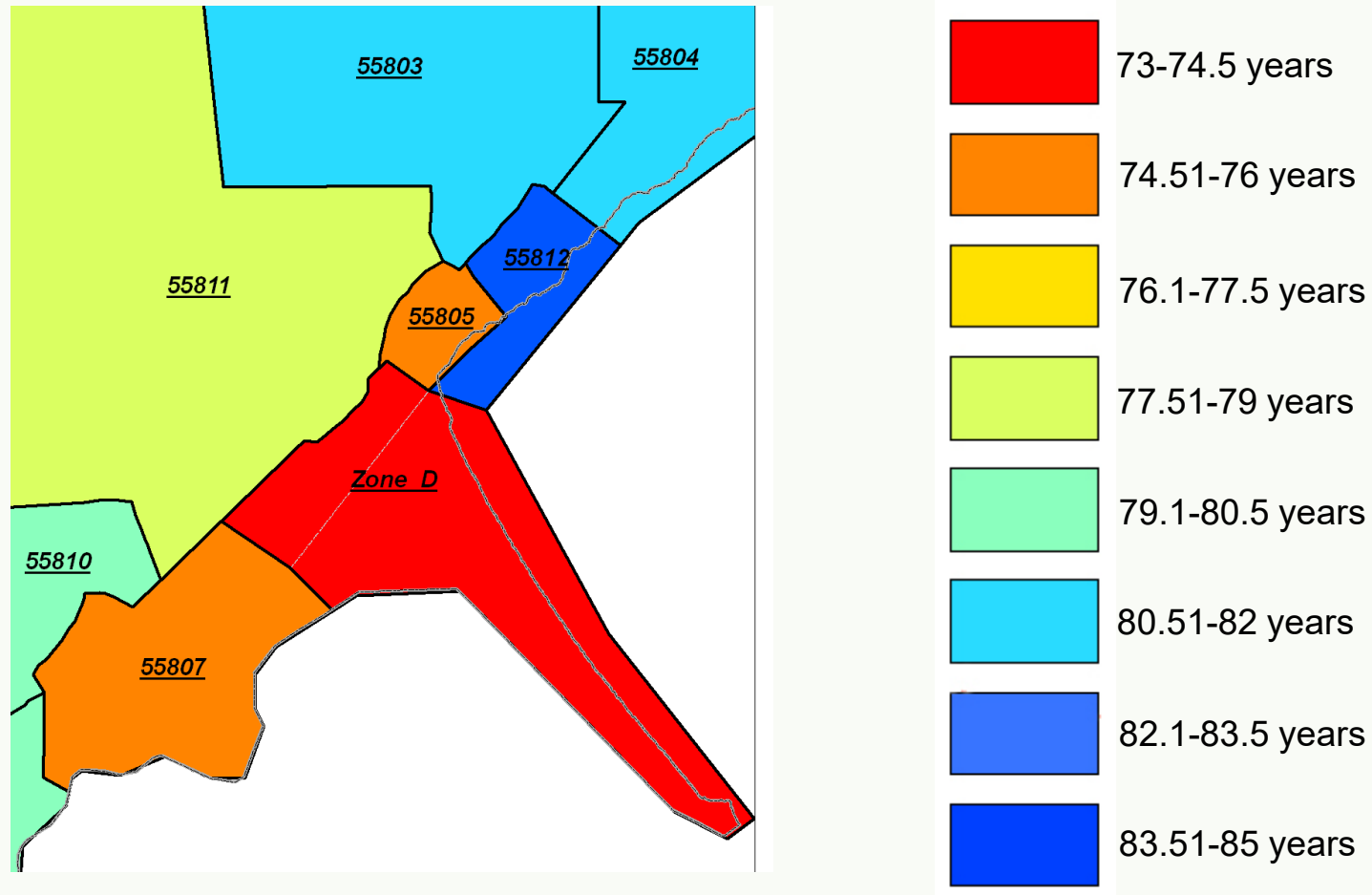


- Prescription opioid use has declined over time – but is still higher in rural areas.
- Some counties in Northern Minnesota have especially high rates of prescriptions.



Source: MDH Health Economics Program and Mathematica Policy Research “Patterns of Opioid Prescribing in Minnesota: 2012 and 2015,” April 2018.
<https://www.health.state.mn.us/data/economics/docs/opioidbrief20185.pdf>

Life expectancy by ZIP code in Duluth



Source: St. Louis County Health Status Report, 2010

County health ranking results

St. Louis County

Health Outcomes 2021 **Ranked 69 (out of 87)**

Length of Life 72

Quality of Life 71

Health Factors **Ranked 45**

Clinical Care 13

Physical Environment 69

Health Behaviors 47

Social & Economic Factors 48



Source: County Health Rankings & Roadmaps 2021

**Panel Discussion 2: *Provider Perspectives on Payment Models for
Incentivizing Improved Management of Care Transitions***

Jenny Reed, MSW

Senior Vice President, Value-based Care
Baylor Scott & White Health



Baylor Scott & White

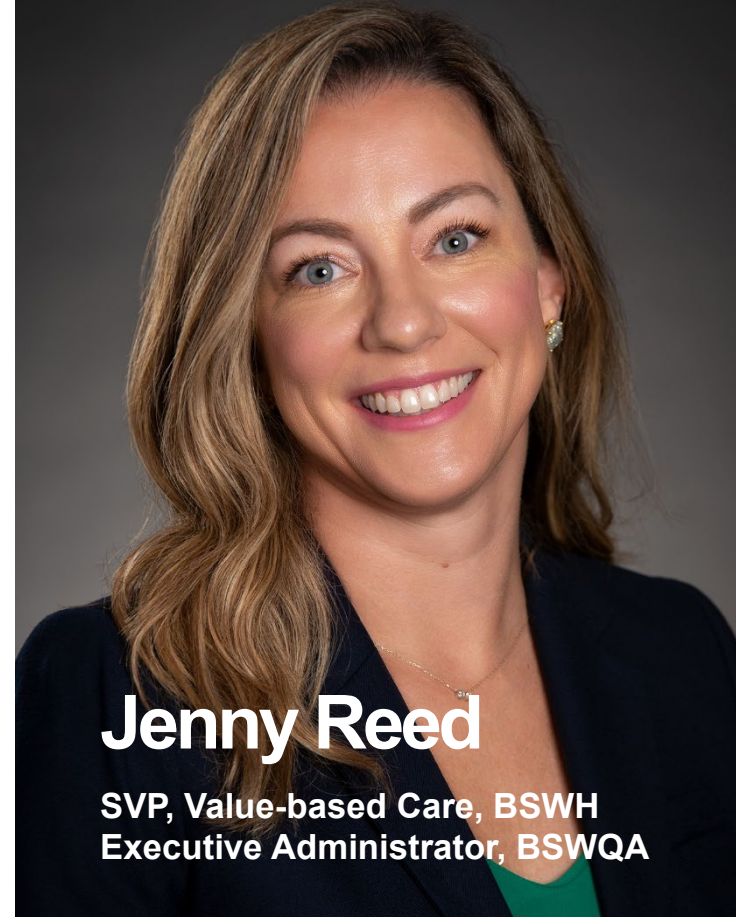
QUALITY ALLIANCE

- Accountable Care Organization
- Clinically Integrated Network
- Longitudinal Care Management with all BSW hospital discharges



- **Providers:** 8,000+
- **Facilities:** 700+
- **Members:** 1 million
- **Geography:** North and Central Texas

www.bswhealth.com/quality-alliance



Jenny Reed

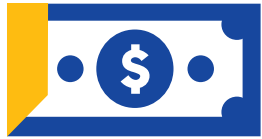
SVP, Value-based Care, BSWH
Executive Administrator, BSWQA

EXPERIENCE

- 20 years in health care
- 10 years in acute care case management
- 10 years in VBC



Value-based care models incentivize the right results



#1 in savings for MSSP in the U.S. for 2020 & 2021.

- Nearly \$300 Million in savings for last three years of [CMS](#) reporting.



Comprehensive Care Management reduces PMPM costs

- Average Medicare = \$83 PMPM
- Medicare members with major / multiple chronic conditions = \$105 PMPM



Reduces unnecessary care

- hospital readmission rate by 12%
- acute hospitalizations by 12%
- preventative care gaps by 21%



Post Acute Care (PAC) utilization 20% below market trend

- 105 PAC providers in the network
- 13,350 admissions to the PAC network in 2022



Skilled Nursing Facility (SNF) length of stay = ~20 days (20% less than market)

- 3,600 patients supported by care management in the SNF Network



**Panel Discussion 2: *Provider Perspectives on Payment Models for
Incentivizing Improved Management of Care Transitions***

Robert M. Wachter, MD

Professor and Chair, Department of Medicine
University of California, San Francisco (UCSF)

The Impact of Federal Policies on Hospitalist-Related Patient Handoffs

Robert M. Wachter, MD
Professor and Chair, Dept. of Medicine
University of California, San Francisco (UCSF)
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PTAC Meeting: June 12, 2023

Relevant Biography

- ▶ Professor and Chair of the Dept. of Medicine, University of California, San Francisco (UCSF), generally ranked as one of the top DOM's in the nation
- ▶ Coined the term “hospitalist” in a 1996 *New England Journal of Medicine* article, and generally considered the academic father of the hospitalist field
- ▶ Expert in patient safety; recipient of the John M. Eisenberg award, the nation's top honor in patient safety; author of the world's most popular patient safety primer, *Understanding Patient Safety*
- ▶ Expert in Digital Transformation; author of the NY Times science bestseller, *The Digital Doctor, Hope, Hype, and Harm at the Dawn of Medicine's Computer Age* (2015); led an NHS committed advising the NHS on its digital future
- ▶ Named most influential physician-executive in the US in 2015 (*Modern Healthcare* magazine); elected member of the National Academy of Medicine; >270,000 followers on Twitter

Three Ideas for Improving Federal Policies Regarding Hospital Care Transitions

1. **Redefine the “3 Midnight Rule”**: The current requirement that patients need to remain in the hospital for 3 midnights before discharging to a skilled nursing facility (SNF) can lead to unnecessarily prolonged hospital stays. The pandemic-era relaxation of this rule should continue, allowing for more flexible and efficient transitions.
2. **Establish Per Diem Payments for Long-Stay Admissions**: Many patients are unable to leave the hospital because of the absence of a suitable receiving institution (SNF, LTAC). Hospitals should be eligible for per diem payment for long-stay admissions, which will help with the financial sustainability of these hospitals as well as healthcare worker burnout. (Of course, addressing the root causes of long-stay patients must be the ultimate goal.)
3. **Promote Bundled Care Models and Transitional Care**: Bundled care models, particularly for the Medicare population, could promote continuity of care, incentivize longer-term post-acute care management, and provide more opportunities for innovation. Adjustments to the model could include creating a pathway to downside risk, using year-over-year performance as cost targets, and considering a 30-60 day bundle, rather than 90 days. There should also be long-term endorsement of the Hospital at Home model as a crucial (and evidence-based) part of transitional care.